




Innovations in  
Graduate Medical Education

---

# Maryland Summit on the Future of Graduate Medical Education

---

**May 20, 2015**  
Mt. Washington Conference Center  
Baltimore, Maryland



# Welcome

**Paul B. Rothman, MD**

The Frances Watt Baker, MD & Lenox D. Baker, Jr., MD  
Dean of the Medical Faculty  
CEO, Johns Hopkins Medicine

# Introduction from the Co-Chairs

**Anthony F. Lehman, MD, MSPH**

Senior Associate Dean for Clinical Affairs, University of Maryland

**Roy C. Ziegelstein, MD, MACP**

Vice Dean for Education, Johns Hopkins School of Medicine

# Background

- New All-Payer Waiver fundamentally changes incentives
- Waiver agreement includes requirement to develop plan for Medical Education
- Presents unique opportunity to re-imagine how training occurs
- Workgroup oversees the development of the plan
- Today's Summit is a critical step in designing the plan

# Charge

*“[D]evelop a five-year plan that will serve as a blueprint for improvement elements necessary to sustain health transformation initiatives in Maryland and which will be generalizable to other schools across the United States.”*

- Sustain health transformation
- Generalizability
- Focus on **Graduate** Medical Education (GME)
- Plan is from the State of Maryland to CMS
- Interdisciplinary

# What the Current System Does Well

- Provides a strong scientific foundation for post-graduate medical education
- Provides highly structured and nationally standardized training for post-graduate physicians, governed by national residency review boards
- Rigorously reviews performance of post-graduate programs in an on-going manner
- Defines and evaluates core competencies of individual trainees required for certification of completion of training

# What Could Be Better in the Future

- Most training today continues to be hospital-based even though most patient care occurs in the ambulatory setting
- Most trainees view their “patient population” as those hospitalized patients they provide care for rather than the patients in the community they serve
- Residency training often does not emphasize high quality, safe, *cost conscious* care which is particularly important as we evolve from a hospital revenue model to a population-based or “total patient revenue” payment model
- Training today does not emphasize team-based care and help residents become effective team members and leaders



# Today's Agenda

- Background Speakers
  - Donna Kinzer – HSCRC
  - Eric Holmboe, MD – ACGME
  - Bruce Blumberg, MD – KP
- Breakout Session 1
  - Review Goals for a new GME Model in Maryland
  - Pre-assigned
- Lunch
  - Speaker: Ankit Patel – CMMI
- Reporting on Breakout Session 1
- Breakout Session 2
  - Planning for a New GME Model in Maryland
  - Self selected
- Reporting on Breakout Session 2
- Sec. Van Mitchell Remarks
- Closing Comments



# GME in Maryland: Waiver Overview and Description GME Funding

**Donna Kinzer**

Executive Director, Health Services Cost Review Commission



# **Funding Graduate Medical Education in Maryland's All Payer System**

Innovations in Medical Education Workgroup  
May 18, 2015

---

---



## Background of Maryland Rate Regulation and New All Payer Model

---

# Health Services Cost Review Commission

---

- ▶ Oversees hospital rate regulation in Maryland
  - ▶ Independent 7 member Commission
  - ▶ Broad statutory authority
    - ▶ Has allowed Commission methods to evolve
  - ▶ Broad support
-

# HSCRC Sets Hospital Rates for All Payers

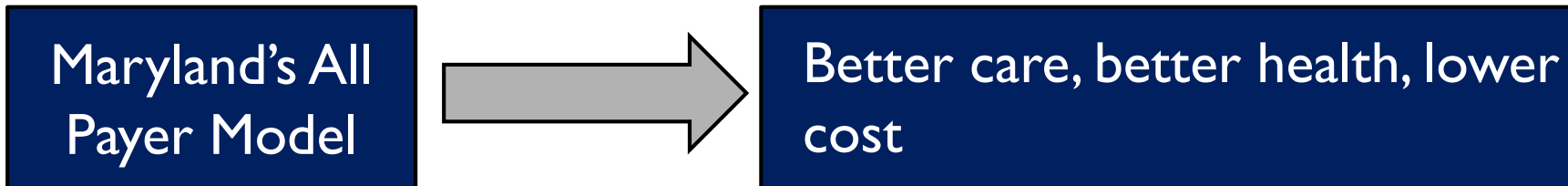
---

- ▶ **All Payer Rate Setting**
    - ▶ Medicare waiver granted in 1977 and renewed under a different approach in 2014 allows HSCRC to set hospital rates for Medicare
    - ▶ State Medicaid plan (for financially and medically needy) requires payment of HSCRC rates
    - ▶ State law requires health insurers, managed care organizations, others to pay HSCRC rates
  - ▶ **All payers pay their fair share of full financial requirements**
    - ▶ Uncompensated Care
    - ▶ Graduate Medical Education
  - ▶ **Considerable value to patients, State and hospitals**
-

# Approved New All-Payer Model

---

- ▶ New All-Payer Model for hospital payment
  - ▶ Approved on January 1, 2014 for a 5 year timeframe
- ▶ Moves Maryland:
  - ▶ From **per inpatient admission** regulation focus
  - ▶ To an **all-payer, total hospital** payment **per capita** focus
    - ▶ Shifts focus to population health and delivery system redesign



# New Model: Key Requirements

---

- ▶ All-Payer total hospital **per capita revenue growth ceiling** of 3.58% annual growth, with savings of at least \$330 million to Medicare over 5 years
  - ▶ **Patient and population centered-measures** and targets to promote care improvement
    - ▶ Readmissions, hospital acquired complications, and others
  - ▶ Payment transformation away from fee-for-service for hospital services
  - ▶ Proposal covering all health spending due at the end of year 3
-



# All Payer Model Implementation

---

## Year 1 Focus (2014)

Global budgets  
Meeting test metrics  
Monitoring infrastructure  
Potentially avoidable  
utilization concepts & data  
Stakeholder input

## Year 2 Focus (2015)

### Clinical improvement & infrastructure

- Better chronic care
- More coordinated care
- Better episodes

### Payment alignment

- Medicare chronic care fees and other innovations
- Gainsharing and Pay-for-Performance
- Dual eligible & integrated networks

## Year 3 Focus (2016)

Implementation of infrastructure, work flows, and models

Engaging patients, families, and communities

Focusing on additional alignment opportunities

Prepare for model extension to incorporate total cost of care—costs beyond the hospital

# Calendar Year 2014 (Year 1) Results

---

- ✓ Under all payer limit (1.47% per capita increase vs. 3.58% limit)
- ✓ Medicare savings on track (subject to review)
- ✓ Quality improvement on track—26% improvement in MHACs in CY 2014, 30% required over 5 years
- ✓ Readmissions down, but more progress needed

## Hospital performance

- ✓ Increased profitability of hospitals overall
  - ✓ Overall volume growth limited
    - ✓ Absorbed 200,000 new Medicaid enrollees
-

---



# Graduate Medical Education Funding in Maryland

---

# Graduate Medical Education (GME) costs is a core component of hospital costs

---

- ▶ HSCRC founders saw GME as a public good and as a component of hospital cost and rates.
  - ▶ The funding provided to hospitals for GME (Direct Medical Education and Indirect Medical Education) is “baked in” to the unit rate structure at the time of a full rate review.
    - ▶ Because this is a “prospective” rate system, the amounts in rates are not the same as the current actual costs.
    - ▶ The amounts in rates are rolled forward annually with adjustments for inflation, volume/population, etc.
  - ▶ By including GME in rates, all payers contribute to funding GME in MD.
-

## Direct Medical Education (DME)

---

- ▶ DME costs include actual salaries and benefits of residents and interns, faculty supervisory expenses, and allocated overhead.
  - ▶ HSCRC collects data on DME costs and FTEs through the financial reporting system.
-

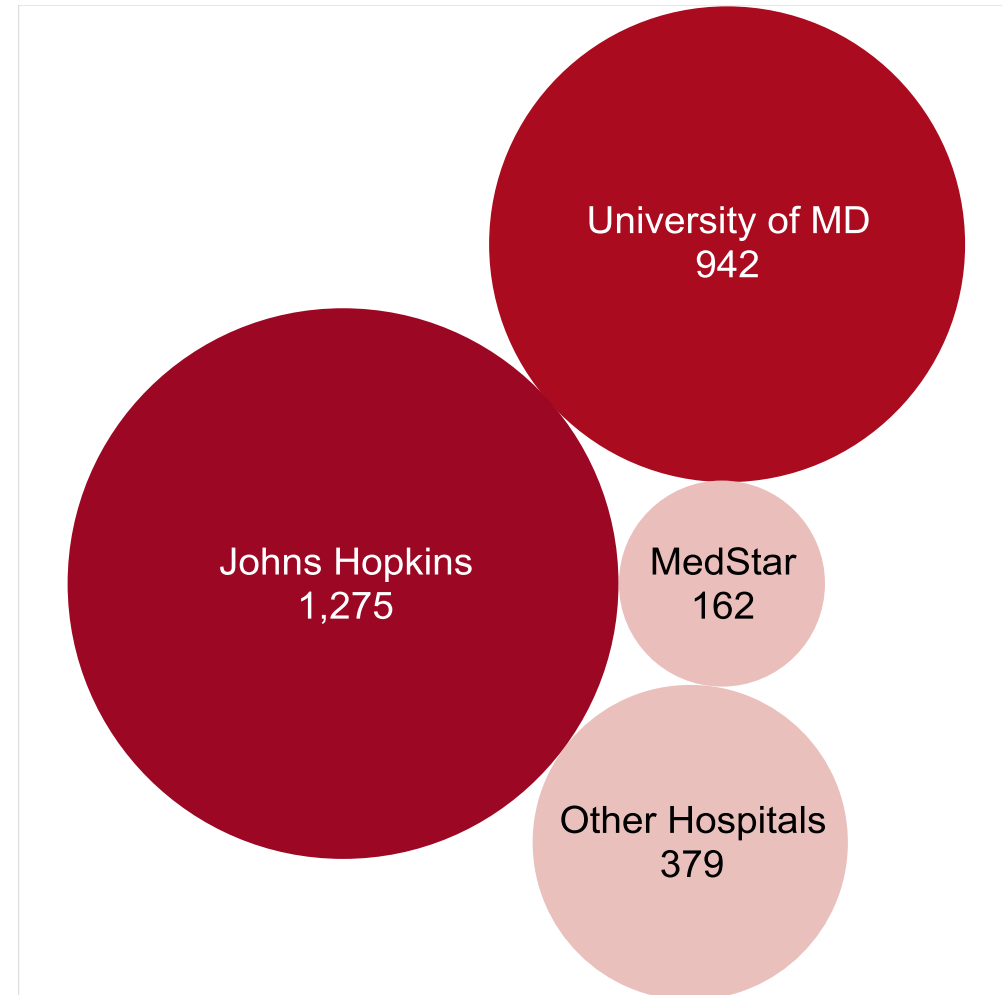
# Number of Residents by Health System

---

**FY2013**

Total Residents = 2,759

Total Program Cost per  
Resident = \$110,996



---

Darker Colors Indicate Higher Growth since FY2008

# Indirect Medical Education (IME)

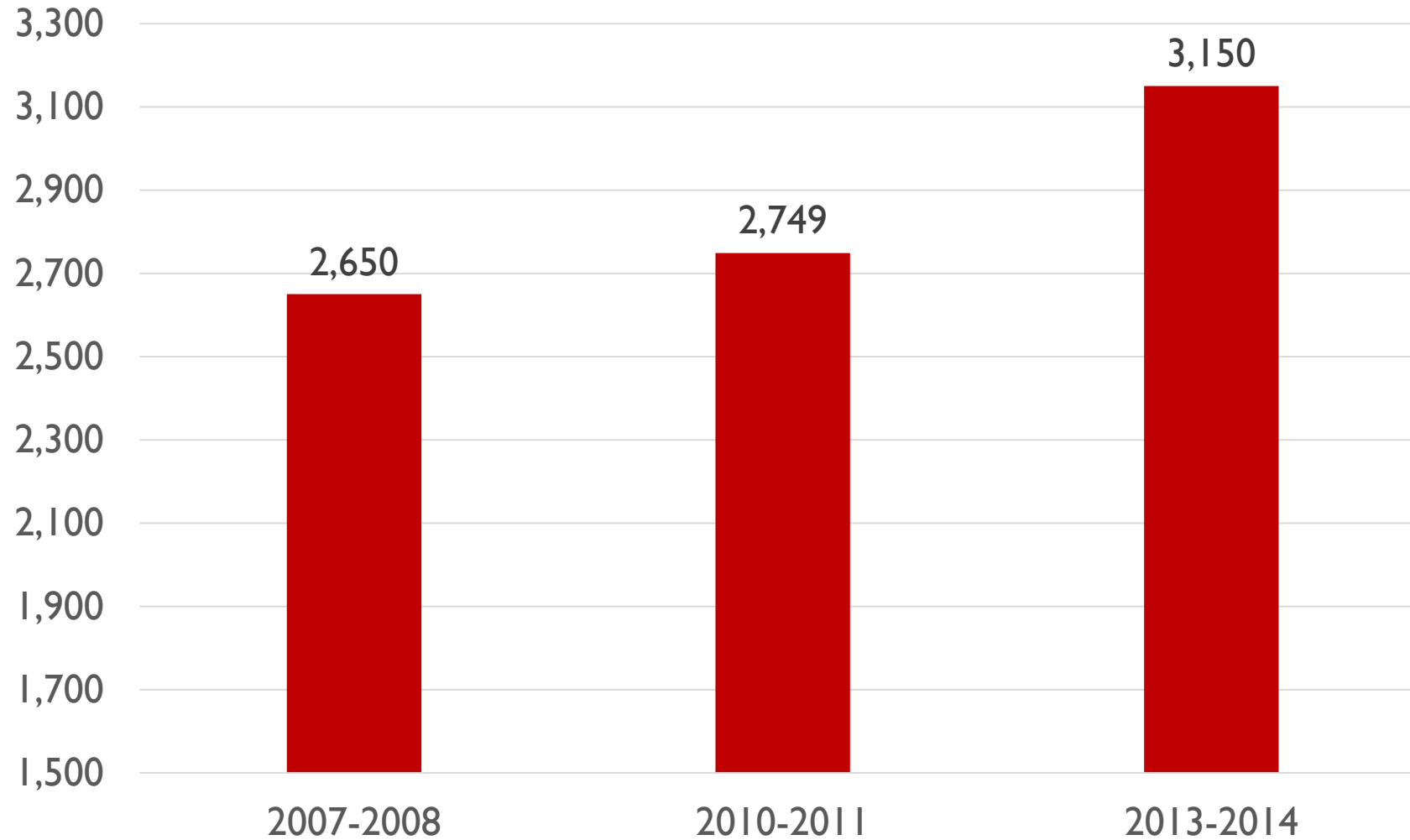
---

- ▶ HSCRC staff estimates IME using a regression model.
    - ▶ IME is an estimate of higher costs associated with teaching-- increased use of tests and ancillary services, greater severity of illness, increased inefficiencies in teaching, etc.
  - ▶ Regression Variables:
    - ▶ Dependent: Adjusted Costs
    - ▶ Independent Variables:
      - ▶ **IME:** Number of full time equivalent residents and interns per case mix adjusted discharge (Source: Medicare's Intern and Resident Information System)
      - ▶ **Poor Share:** Percentage of Medicaid as primary payer, bad debt, charity care, dual eligibles
  - ▶ Coefficients represent estimated dollars for IME and poor share, which can be used to capture unexplained cost differences.
  - ▶ Concerns exist regarding what IME measures.
-



# Number of Residents in MD

---



---

Source: GME Data Resource Books from ACGME

# Estimated GME Costs Realized in FY 2013

---

▶ DME.....\$306,182,780

▶ IME.....\$545,237,171

---

▶ Total.....\$851,419,951

▶ Percent of Total Revenue.....6.1%

---

## MD vs. National Funding of GME

---

- ▶ **Maryland:** DME and IME funded directly on an all-payer basis through rates at the amount determined during a full rate review + annual adjustments.
  - ▶ **National:** Medicare funds DME outside of PPS in proportion to Medicare percentage and cap. IME funded through add on for Medicare inpatient payments. Variation in how other payers compensate for GME—Medicaid has various approaches it uses, other payers negotiate rates.
-

---

Questions?

---

# Innovations in GME: The ACGME Perspective

**Eric S. Holmboe, MD**

Senior Vice President, Milestone Development and Evaluation  
Accreditation Council for Graduate Medical Education

---

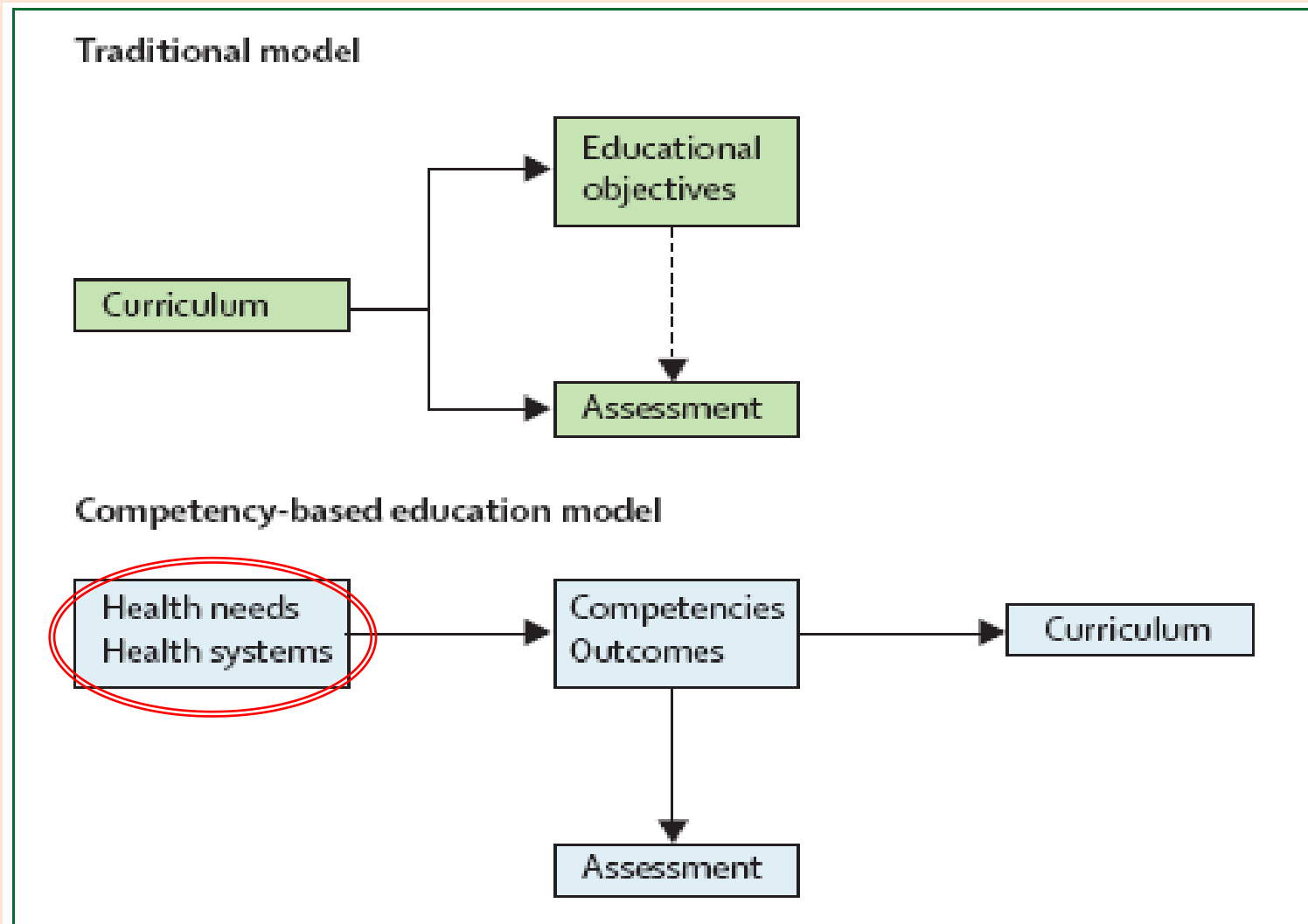


# Disclosures

- Employed by the ACGME
- I receive royalties from Mosby-Elsevier for a textbook on assessment
- I am a member of the board of NBME and Medbiquitous
- Professor Adjunct, Yale University
- Adjunct Professor, USUHS

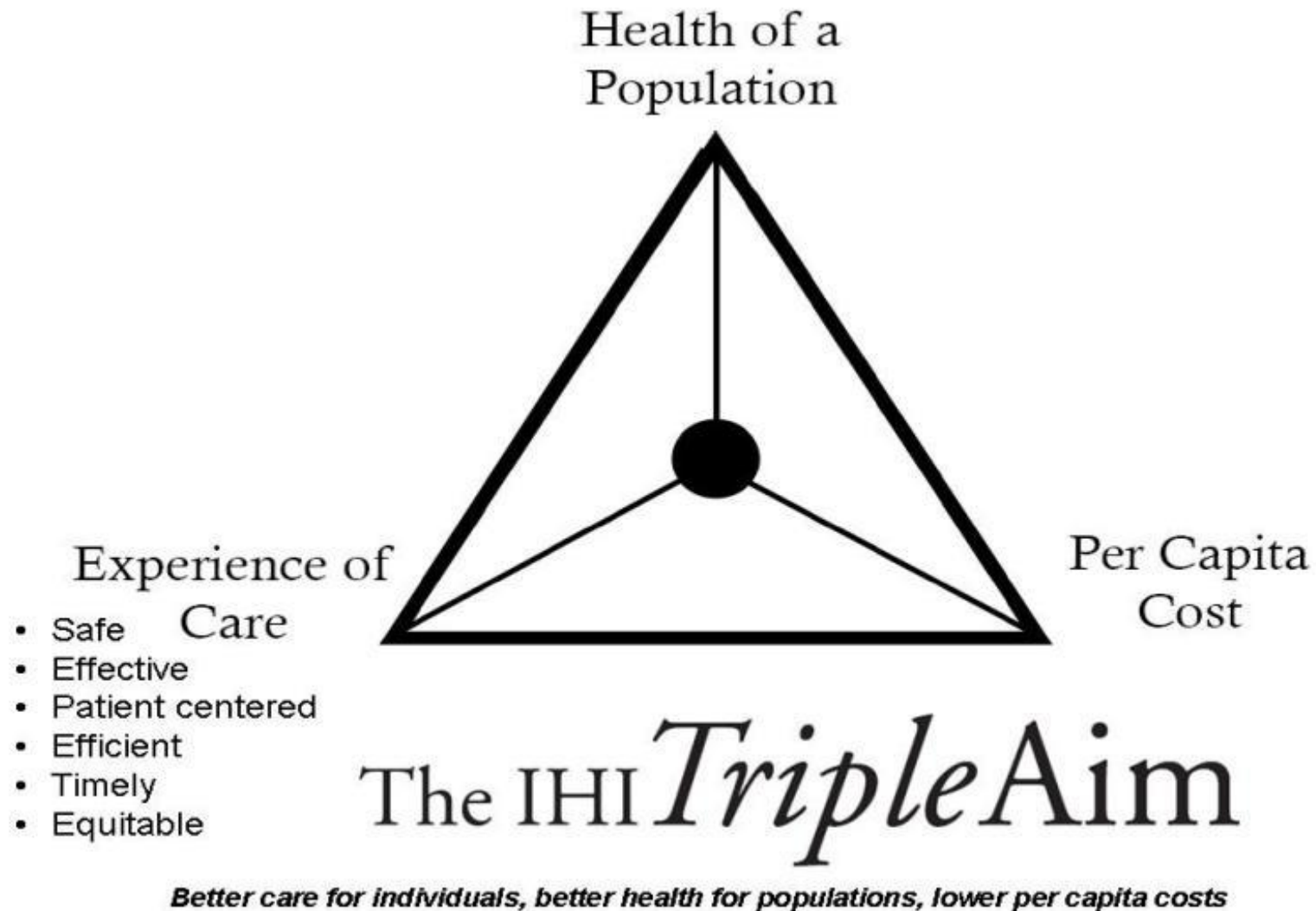


# Why CBME: System Needs

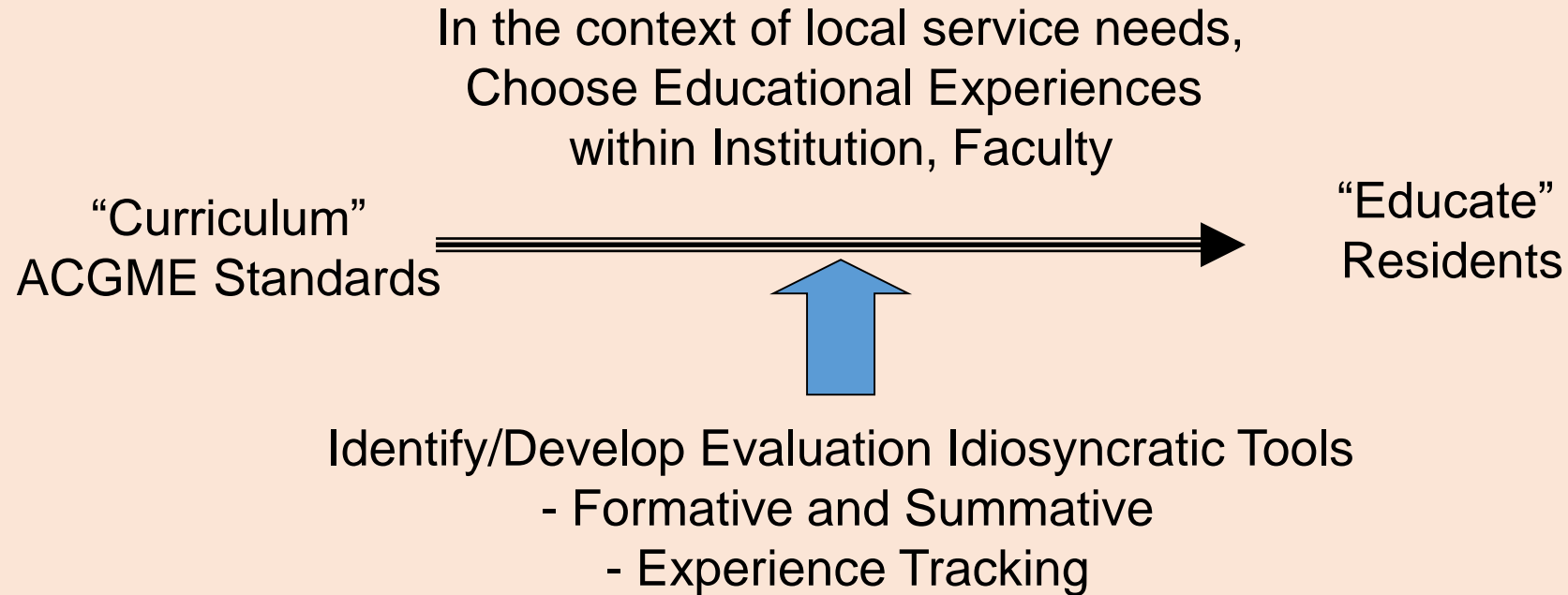




# What Are The Outcomes?

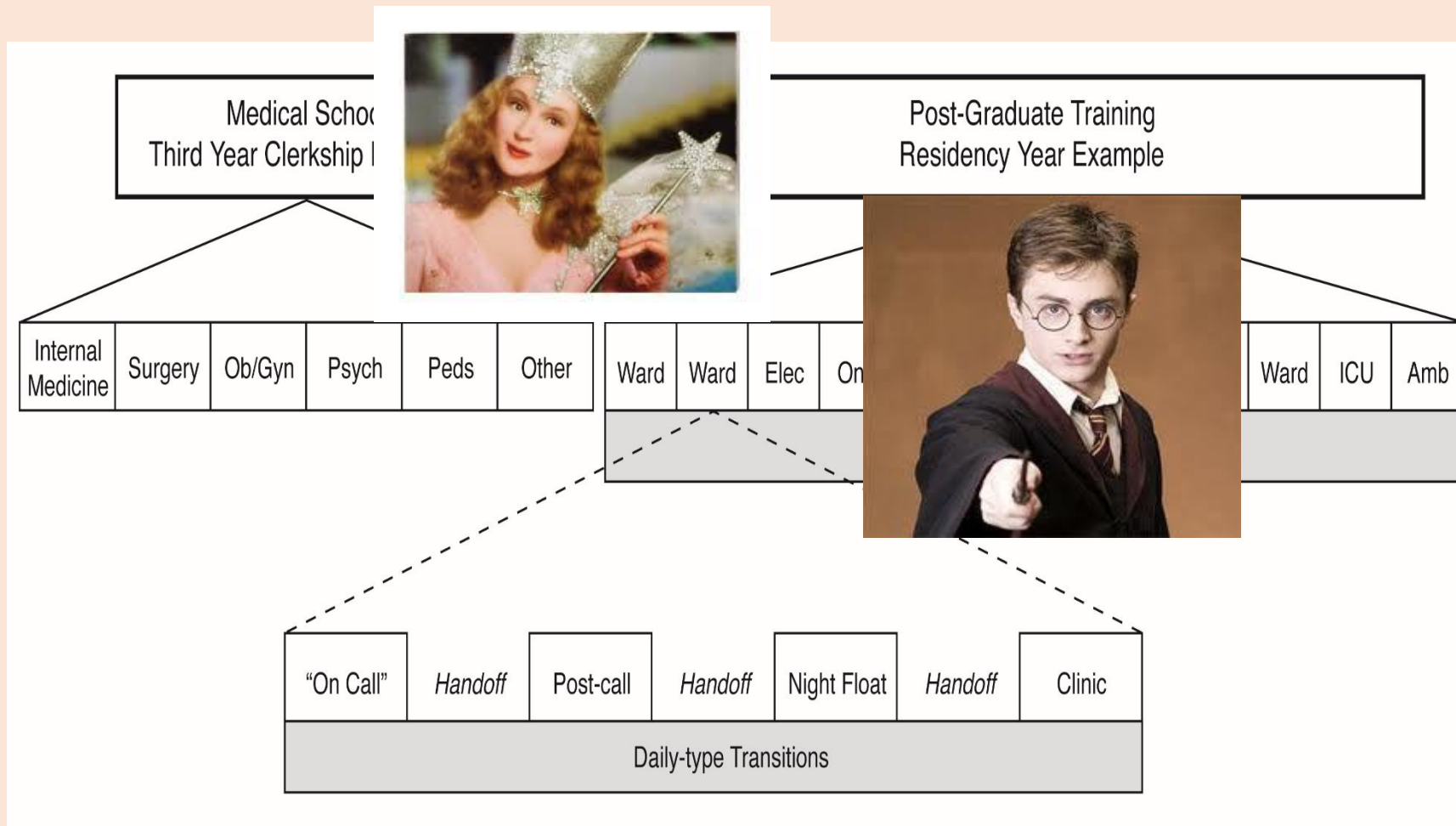


# What Currently Drives the Structure and Content of our Residency Programs?



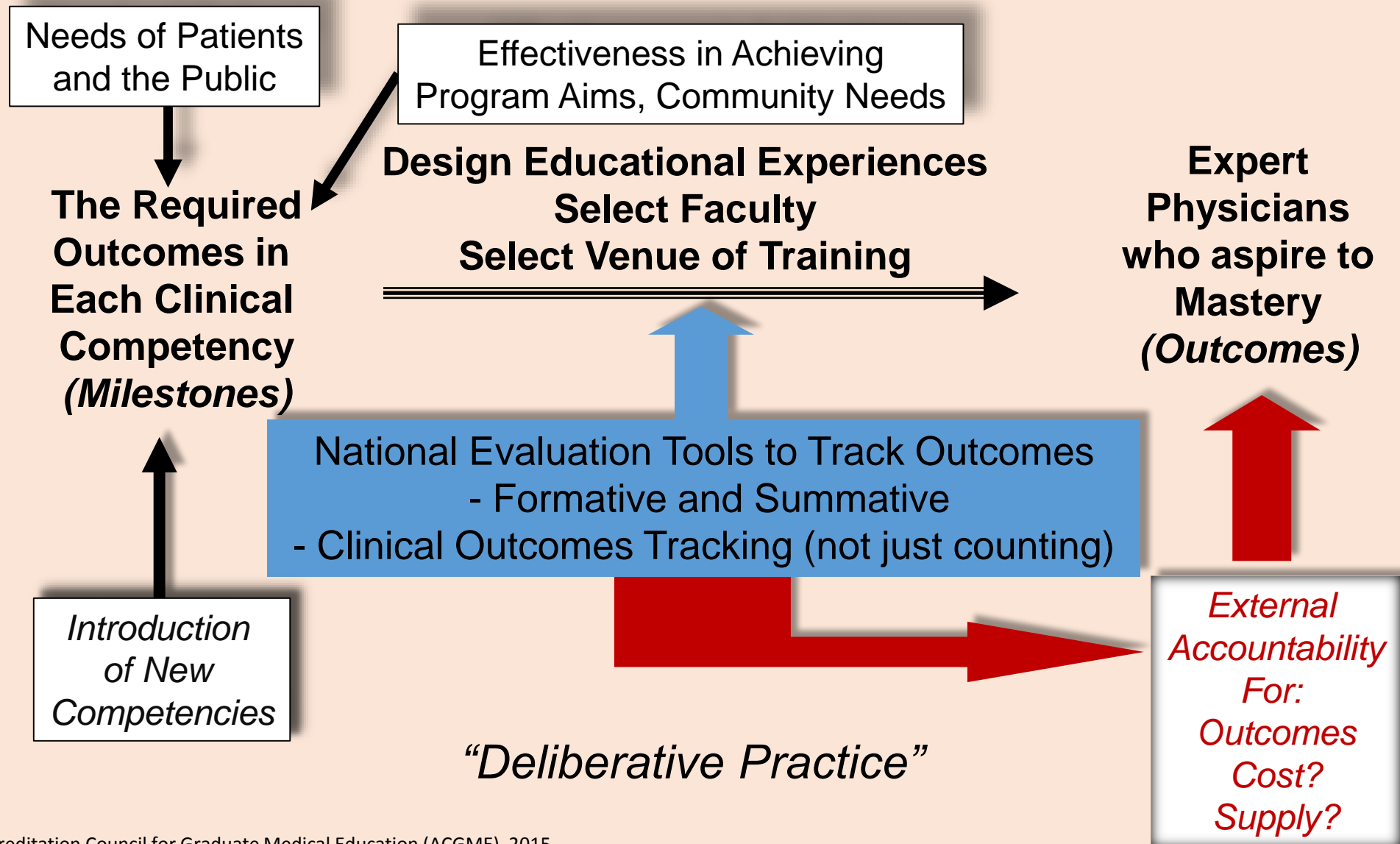
*“Circumstantial Practice”*

# Medical Education Architecture<sup>1</sup>

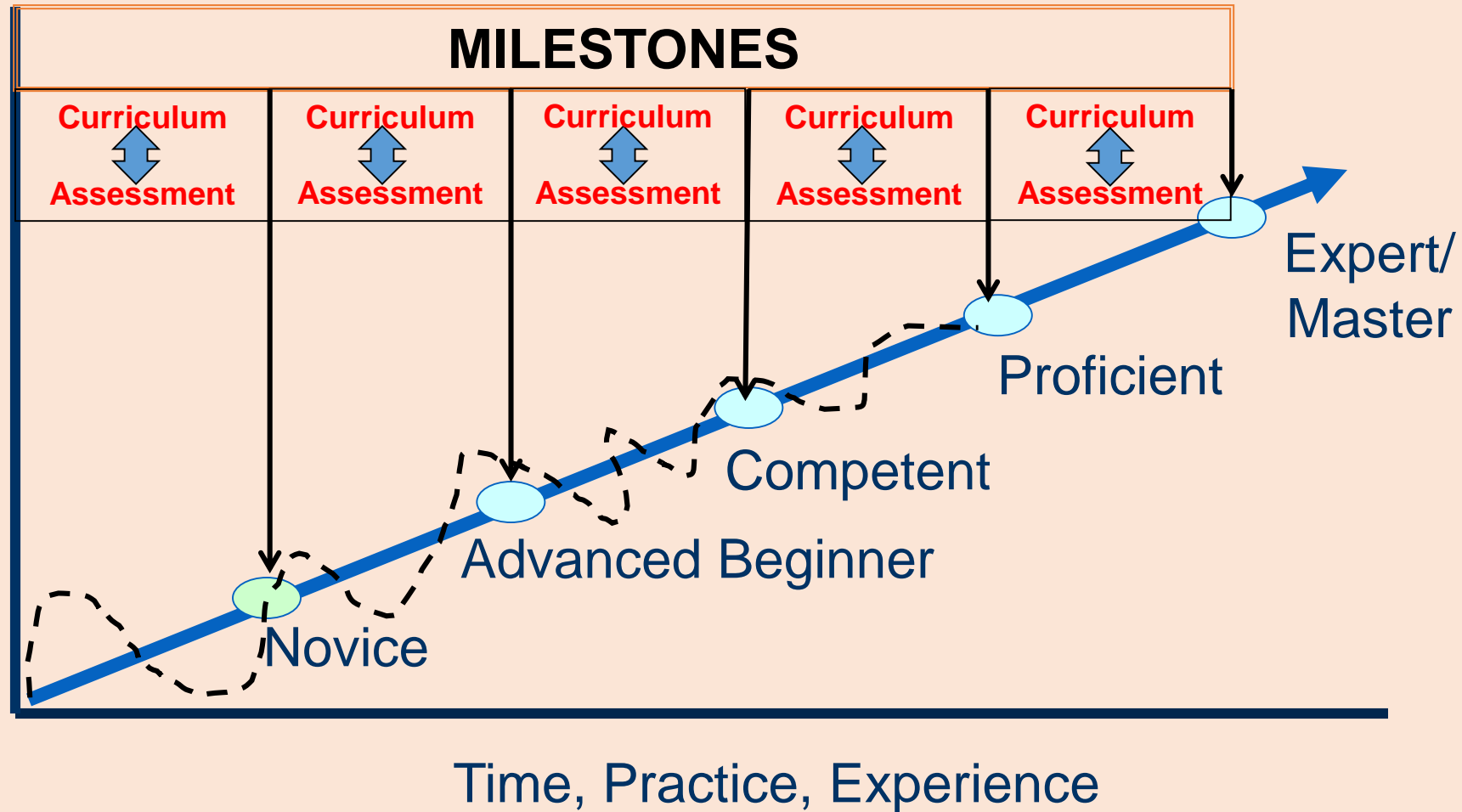


<sup>1</sup>Holmboe E, Ginsburg S, Bernabeo E. The rotational approach to medical education: time to confront our assumptions. Med Educ. 2011; 45(1):69-80.

# What Will Drive the Structure and Content of our Residency Programs in the Near Future?

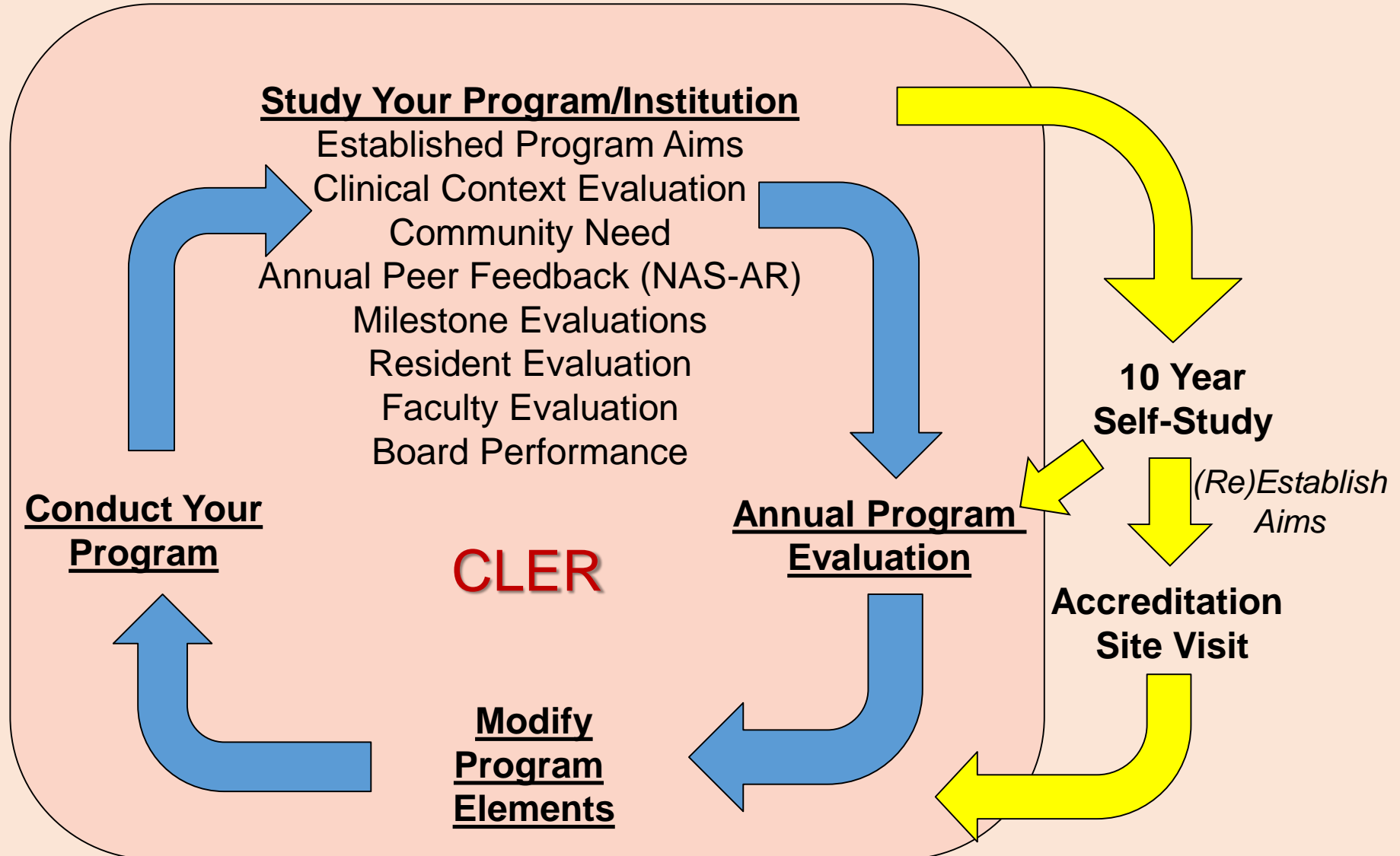


# Dreyfus & Dreyfus Development Model

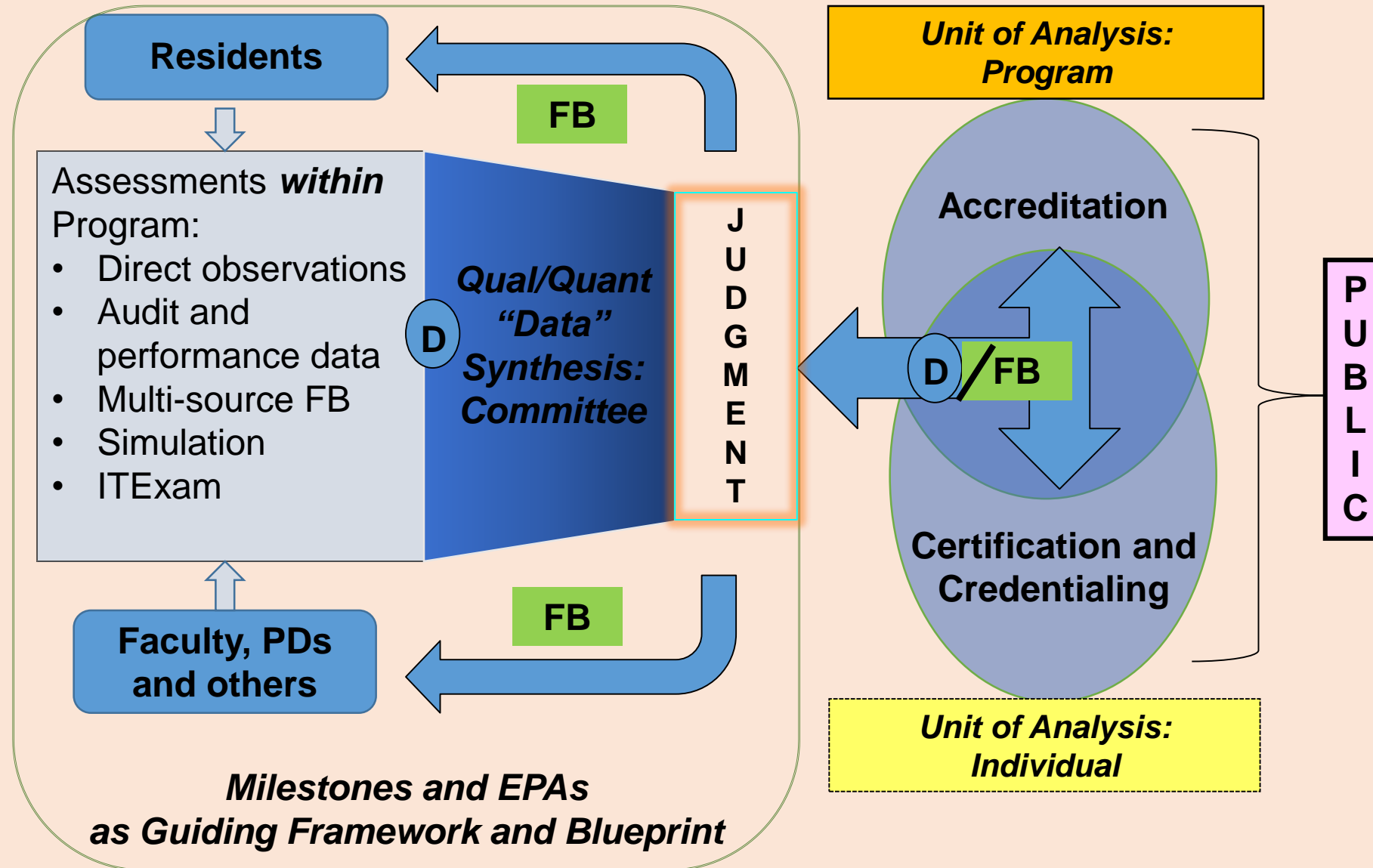


# NAS – A Continuous Improvement Cycle

“Practice Based Learning and Improvement for Programs”  
Goal: *Excellence in Achievement of Program Aims*



# The Professional Self-Regulatory Assessment “System”





# Milestones: Purposes and Implications



***Milestones are a Formative Assessment Framework***

# What Milestones Are *Not*

- A **complete** description of:
  - Clinical competence of any individual
  - ***All*** elements of competence in a specialty/subspecialty
  - Promotion Criteria
  - Graduation Criteria
- The ***totality*** of a discipline
- A “checklist” to simply complete without discussion
- The sole determinants to be used in Competency Based Medical Education (CBME)
- “Tools” to Close Programs

# Innovation Crucial

**\*Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

**Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Detail Requirements: “Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet the Core Requirements”

# Thank You



## Questions and Discussion



[eholmboe@acgme.org](mailto:eholmboe@acgme.org)

# GME in the Accountable Care ERA – The Kaiser Permanente Experience

**Bruce D. Blumberg, MD**

Director of Physician Education and Development  
Kaiser Permanente Northern California

---





# **GRADUATE MEDICAL EDUCATION IN THE ACCOUNTABLE CARE ERA**

THE KAISER PERMANENTE EXPERIENCE

Bruce Blumberg, MD  
Director of Graduate Medical Education  
Kaiser Permanente Northern California

Presented at State of Maryland GME Summit  
Baltimore, May 20, 2015

# Agenda

- **The GME Landscape**
- A Re-Introduction to Kaiser Permanente
- KP's Approach to GME – What Can be Extrapolated
- Q&A



# The GME Landscape

- **The Mis-Match**
- GME Funding Tectonics
- Mission Clash
- The Rise of the Clinical Learning Environment
- The Age of Innovation
- Redefining Accreditation



# The GME Landscape

- The Mis-Match
- **GME Funding Tectonics**
- Mission Clash
- The Rise of the Clinical Learning Environment
- The Age of Innovation
- Redefining Accreditation

# The Calculus of GME

## Revenues:

- CMS DME reimbursement
- CMS IME reimbursement
- Resident/fellow service offset
- Impact on recruitment and retention of faculty
- Impact on organizational reputation
- Impact of trainees on cost of care (?)

# The Calculus of GME

## Costs:

- Resident/fellow salaries + T&B
- Coordinator salaries + T&B
- Defined non-payroll costs
- Faculty salaries + T&B for teaching, supervision, administration and residency-related research
- Impact of trainees on cost of care (?)

# The GME Landscape

- The Mis-Match
- GME Funding Tectonics
- **Mission Clash**
- The Rise of the Clinical Learning Environment
- The Age of Innovation
- Redefining Accreditation



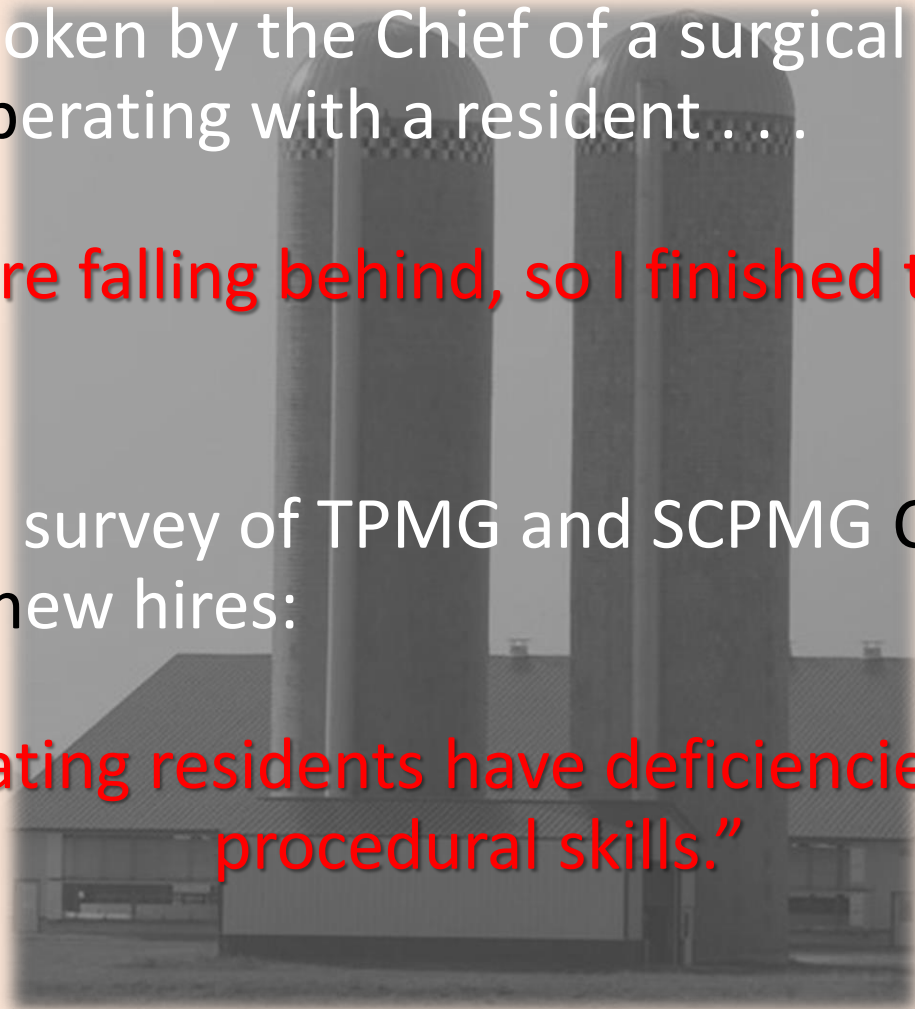
# One Mission; Competing Priorities

- Recently spoken by the Chief of a surgical department, who was operating with a resident . . .

**“We were falling behind, so I finished the case.”**

- Results of a survey of TPMG and SCPMG Chiefs in describing new hires:

**“Graduating residents have deficiencies in their procedural skills.”**



# The GME Landscape

- The Mis-Match
- GME Funding Tectonics
- Mission Clash
- **The Rise of the Clinical Learning Environment**
- The Age of Innovation
- Redefining Accreditation



# CLER Program: 6 Focus Areas

---

- ✱ Integration of residents/fellows (along with demonstration of impact) into:
  - ✱ Patient Safety Programs
  - ✱ Quality Improvement Programs
    - ✱ Reduction of Disparities in Health Care Delivery
- ✱ Supervision
- ✱ Transitions in Care
- ✱ Duty hours policy, fatigue management and mitigation
- ✱ Professionalism (including Honest and Accurate Reporting of Information, Scientific Integrity and Issues of Mistreatment)

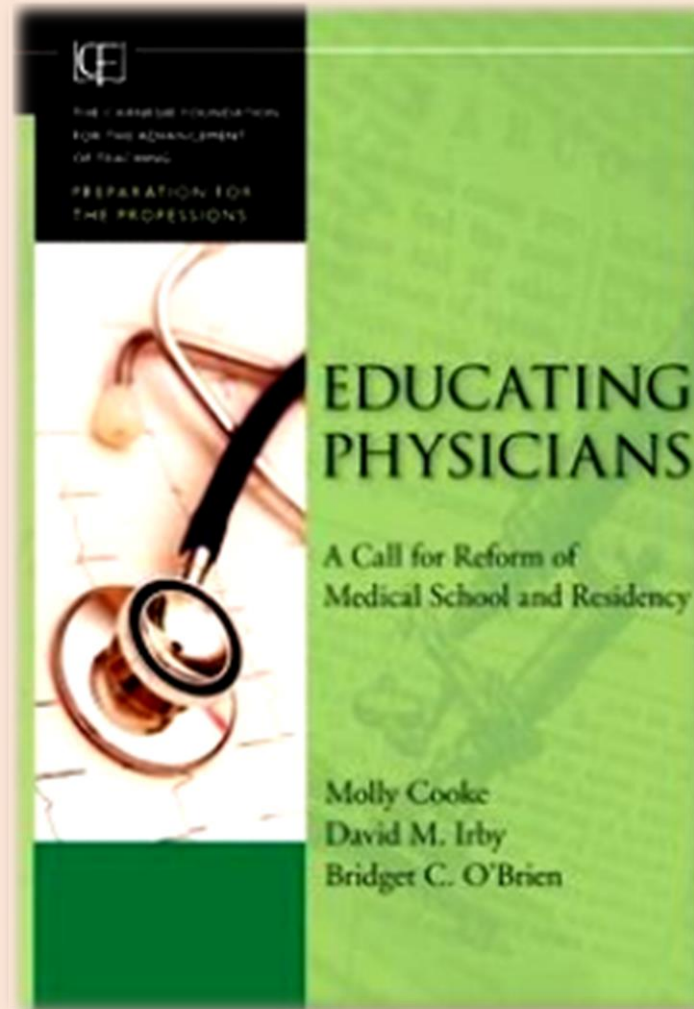




# The GME Landscape

- The Mis-Match
- GME Funding Tectonics
- Mission Clash
- The Rise of the Clinical Learning Environment
- **The Age of Innovation**
- Redefining Accreditation

# Reforming Medical Education



# Innovation in Medical Education

- Curricular redesign
- Emphasis on longitudinal education (UME → GME)
- Shift from time basis to competency basis
- Emphasis on team-based care, population medicine, and care systems
- Explicit recognition of the essential role of partnering systems to impart 21<sup>st</sup> century skills
- Distance learning, MOOCs, and the Regional Medical Campus
- For-profit medical schools

# The GME Landscape

- The Mis-Match
- GME Funding Tectonics
- Mission Clash
- The Rise of the Clinical Learning Environment
- The Age of Innovation
- **Redefining Accreditation**

# Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA

Sean Nicholson, PhD

Sindhu Srinivas, MD, MSCE

Jeph Herrin, PhD

Andrew J. Epstein, PhD, MPP

**M**ANY PHYSICIANS AND NON-physicians likely assume that some residency programs tend to produce better physicians than others—either because those residency programs train physicians better or because those residency programs can recruit more capable trainees. Although plausible, these intuitions have not been empirically tested. This information could be useful in at least 2 different ways.<sup>1</sup> First, identifying which training programs produce better physicians and separating out the effects that are due to the ability to attract better trainees might indicate what makes better programs better. Some of these factors might be exportable to other programs, raising the quality of medical education more broadly. Second, by

**Context** Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

**Objective** To assess whether obstetrics and gynecology residency programs can be evaluated by the quality of care their alumni deliver.

**Design, Setting, and Patients** A retrospective analysis of all Florida and New York obstetrical hospital discharges between 1992 and 2007, representing 4 906 169 deliveries performed by 4124 obstetricians from 107 US residency programs.

**Main Outcome Measures** Nine measures of maternal complications from vaginal and cesarean births reflecting laceration, hemorrhage, and all other complications after vaginal delivery; hemorrhage, infection, and all other complications after cesarean delivery; and composites for vaginal and cesarean deliveries and for all deliveries regardless of mode.

**Results** Obstetricians' residency program was associated with substantial variation in maternal complication rates. **Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had an adjusted complication rate of 13.6%, approximately one-third higher than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile** (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar. Adjustment for medical licensure examination scores did not substantially alter the program ranking.

**Conclusions** Obstetrics and gynecology training programs can be ranked by the maternal complication rates of their graduates' patients. These rankings are stable across individual types of complications and are not associated with residents' licensing examination scores.

*JAMA.* 2009;302(12):1277-1283

[www.jama.com](http://www.jama.com)

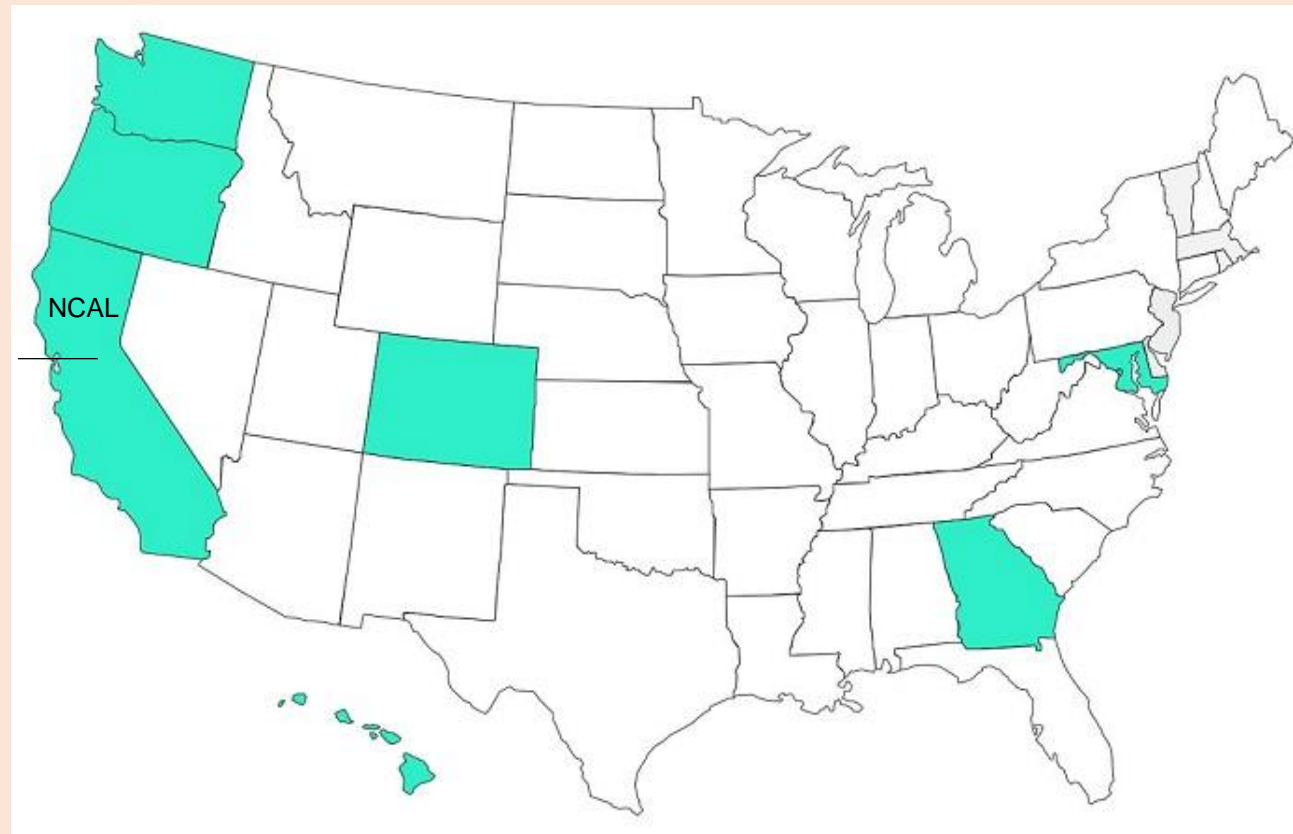
# Agenda

- The GME Landscape
- **A Re-Introduction to Kaiser Permanente**
- KP's Approach to GME – What Can be Extrapolated
- Q&A





- Kaiser Permanente (KP) is the largest non-governmental integrated health care system in the USA
- KP provides health care to 10.1 million people in 7 regions in the USA







- Kaiser Permanente is a registered service mark, not a legal entity.
- Kaiser Foundation Health Plan: a national not-for-profit health maintenance organization.
- Kaiser Foundation Hospitals: a national not-for-profit “hospital” owner/operator.
- Permanente Medical Groups: autonomous, regionally-based medical service provider groups.
- The Permanente Federation: a loosely affiliated umbrella organization fostering collaboration on issues of common interest.



# Principles of Permanente Medicine

- Multispecialty group practice
- Salaried physician self-governance and self-management
  - **Collective “autonomy” (i.e. acting with a sense of choice, willingness, and responsibility)**
  - **Stewardship**
  - Physician leadership
- Partnership with a nonprofit health plan
  - History of prepayment (emphasis on prevention)
  - Longitudinal population of accountability
- Data-driven, evidence-based practices
- Strict prohibition of conflict of interest
- Technologically enabled innovations in healthcare delivery
- Mission includes clinical care, teaching, and research

# What qualities does Kaiser Permanente look for in its primary care physicians?

- Clinical knowledge and skills
- Cost-effective approach to problems
- Commitment to life-long learning
- Professionalism and ethics
- Communications skills
- Emotional I.Q.
- Positive attitude
- Team player

By Francis J. Crosson, Jean Leu, Beth M. Roemer, and Murray N. Ross

# Gaps In Residency Training Should Be Addressed To Better Prepare Doctors For A Twenty-First- Century Delivery System

HEALTH AFFAIRS 30,NO. 11 (2011): 2142–2148

Deficiencies identified in the following areas:

- *Outpatient management of routine conditions and/or common procedures*
- *Care coordination*
- *Continuity of care*
- *Systems thinking*

“Many newly trained physicians were unfamiliar with a variety of team-based care models.”

“Few newly trained physicians understand the social context of disease processes.”

“Some chiefs felt that shifts in attitude were diminishing physician professionalism.”

# Kaiser Permanente as a Research Institution

- \$200M funding in 2012, 80% from external grants
- 1200 active research projects in progress
- >400 1<sup>st</sup>-authored peer-reviewed publications per year
- Expertise in RCTs, prospective or retrospective cohort studies, interrupted time series analyses, nested case-control studies, and cross-sectional studies

# Agenda

- The GME Landscape
- A Re-Introduction to Kaiser Permanente
- **KP's Approach to GME – What Can be Extrapolated**
- Q&A



# California Kaiser Permanente Residencies and Fellowships

[residency.kp.org](https://residency.kp.org)

- Allergy
- Cardiology (2)
- Community Medicine (6)
- Dermatology
- Diagnostic Radiology
- Cardiac Electrophysiology
- Emergency Medicine
- Endo-urology
- Family Medicine (7)
- Gastroenterology
- Geriatrics (2)
- Hand Surgery
- Head and Neck Surgery
- Healthcare Delivery Science
- Hospice & Palliative Med
- Interventional Cardiology
- Internal Medicine (5)
- Internal/Preventive Medicine
- Nephrology
- Neurology
- Obstetrics/Gynecology (4)
- Orthopedics-Sports Med (2)
- Orthopedic Spine Surgery
- Patient Safety
- Pediatrics (2)
- Pediatric Hospital Medicine
- Pediatric Neurosurgery
- Psychiatry
- Radiation Oncology
- Surgery
- Family Med-Sports Medicine (2)
- Urology



# The Strategic Benefits of GME

- Workforce Development
- Community Benefit
- Dissemination of Permanente Principles
- Professional Satisfaction/Faculty Recruitment
- Reputation
- Leveraging of Centers of Excellence

# Kaiser Permanente Residency Programs: Creating Physicians for the 21st Century

## Key advantages:

- GME is funded and treated as a community benefit
- 50% of our graduating residents become future members of our own workforce
- Proudly and strictly independent of industry (pharma and medical device) support
- Training is embedded in a high quality, innovative, population-based healthcare delivery system
  - Faculty members are predominantly practicing physicians
  - Functional model of primary care
  - Longitudinal professional relationships with members and patients
  - Well developed population management infrastructure
  - Interdisciplinary, team-based care
  - Robust electronic health record and practice management data
  - Reimbursement model encourages innovative modes of care
  - Rich opportunities for epidemiologic research
  - Physician participation and leadership in all aspects of the healthcare enterprise
  - Systematic approach to quality and performance improvement

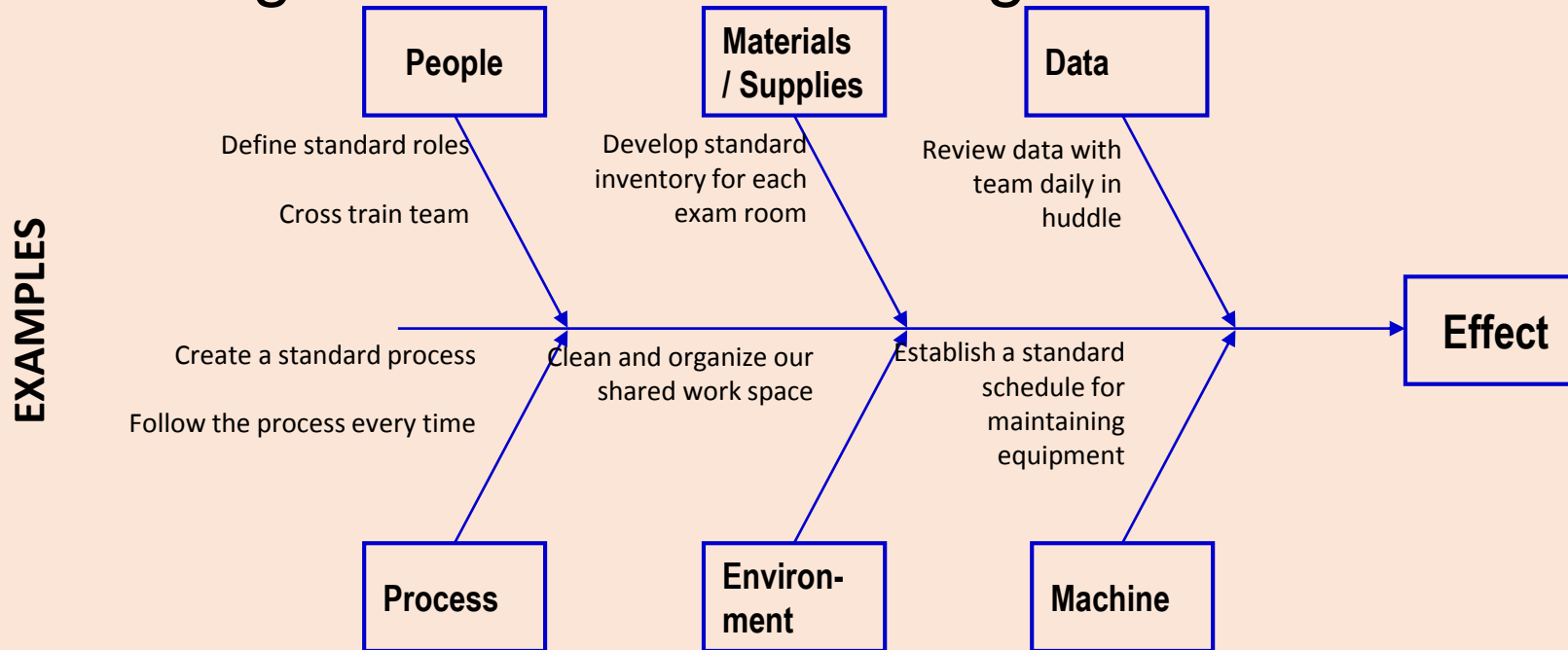


# What Can Be Learned from KP's GME Experience?

- GME as a Community Benefit
- University Partnerships
- One Mission!
- Climate and/or Curriculum?
- Pipeline Development
- Differentiation
- Populations Comprise Individuals
- The Power of the Ripple Effect

# Exercise #6: Brainstorm Solutions with a Partner (5 min)

- Brainstorm solutions to your problem
- **BE SPONTANEOUS** ... **Be Open** ... **Do Not JUDGE**
- Consider using a Cause & Effect Diagram



# News from UC Davis Health System

[Health System](#) > [Newsroom](#) > [Nuevo programa de UC Davis para la nueva ...](#)

NEWS | May 4, 2015

## Nuevo programa de UC Davis para la nueva generación de médicos para la promoción de la salud latina

**Editor's note:** [View this release in English](#)

**(SACRAMENTO, Calif.)** — La Universidad de California, Davis y The Permanente Medical Group lanzaron hoy un nuevo proyecto en la Facultad de Medicina UC Davis, que tiene por objeto preparar a la próxima generación de médicos abocados a la promoción de la salud de los latinos.

# Agenda

- The GME Landscape
- A Re-Introduction to Kaiser Permanente
- KP's Approach to GME – What Can be Extrapolated
- Q&A



# Introduction to Breakout

## Session 1

### Goals of a New GME Model

**John M. Colmers**

Vice President, Health Care Transformation and Strategic Planning,  
Johns Hopkins Medicine

Chair, Health Services Cost Review Commission

# Goals of a New GME Model

- **OBJECTIVE:** Review and validate objectives for the new GME system described in the Charge Document
  1. It should be focused on the Triple Aim.
  2. It should include specific curricula that address population health.
  3. It should be funded in an equitable and efficient manner.
  4. It should augment what is good about residency training today.
- **REPORT OUT:** Any additions/subtractions/modifications to the list of goals

# Goals of a New GME Model

- **SAMPLE DISCUSSION QUESTIONS:**

1. Are the objectives clear?
  - a. How would they be modified?
  - b. Could the descriptions in the paper be improved?
  - c. How will we know they have been achieved?
2. Should any of these be *excluded*?
3. Should any new objectives be *added*?
4. Are they broad enough to cover all GME programs?
5. Do they cover needs for interdisciplinary training?

# GME Under the New Maryland All-Payer Model Agreement

**Ankit Patel, JD**

Senior Advisor,

Center for Medicare & Medicaid Innovation





# Graduate Medical Education Reform: The Maryland All-Payer Model



# Maryland operates the only all-payer rate setting system in the U.S.

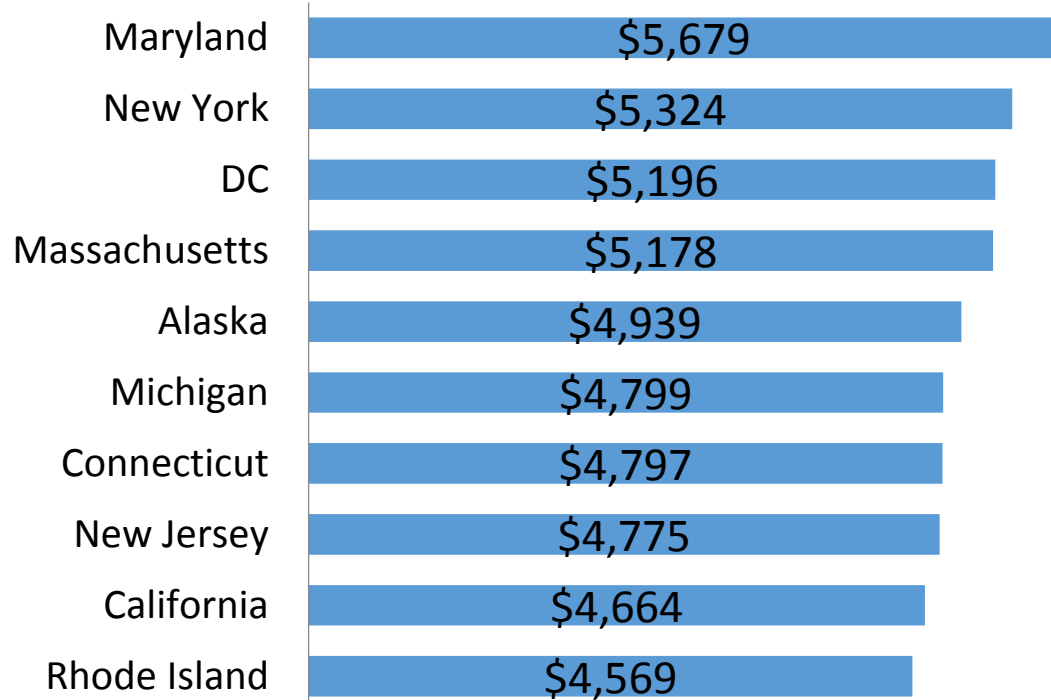
Since 1977, Maryland's Health Services Cost Review Commission (HSCRC) has set hospital rates for all payers. This system:

- Reduces cost-shifting between payers
- Provides a stable and predictable payment system for hospitals
- Promotes equitable financing of uncompensated care and medical education

The primary goal of all-payer rate setting is to control hospital costs.

# Maryland per capita hospital expenditures highest among states

## Top ten states by total Medicare per capita hospital spend (2010)

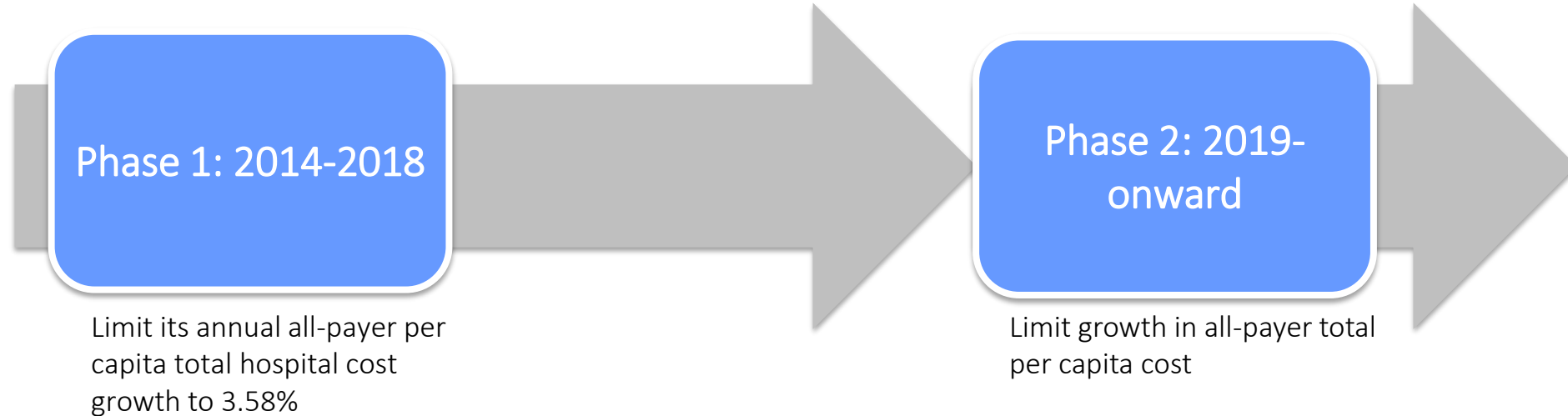


- CMS paid Maryland hospitals \$1.2 billion in 2010 more than they would have received under the national Medicare payment system
- Projected 2013 total Medicare *per capita hospital cost* in Maryland is 32% higher than the national mean
- Projected 2013 total Medicare *per capita cost* is 17% above the national mean

# Model Test

- Whether hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing population health
- Whether new payment and delivery system models implemented in the context of an all-payer rate setting will have greater sustainability and impact when compared to payment and delivery system models in other states

# Maryland All-Payer Model



- Maryland agreed to permanently shift away from its current statutory waiver, exchange for the new Innovation Center model based on Medicare per capita total hospital cost growth.
- In phase 2, Maryland would become the first state in the nation to cap all-payer per capita total cost of care
- If Maryland does not meet terms of the model, Maryland hospitals will transition to the national Medicare payment systems.

# Maryland All-Payer Model

- Limit annual all-payer per capita total hospital cost growth to 3.58%
- Generate *at least* \$330 million in Medicare savings over a five year performance period
- Shift virtually 100% of its hospital revenue over the five year model into global payment models
- Reduce the aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate in Maryland to the national rate over five years
- Achieve an annual aggregate reduction of 6.89% across the 3M 65 Potentially Preventable Conditions (PPCs) over five years for a cumulative reduction of 30%

# Graduate Medical Education

The State must convene medical schools and schools of health professionals in Maryland to develop a five-year plan that will serve as a blueprint for improvement elements necessary to sustain health transformation initiatives in Maryland and which will be generalizable to other schools across the United States. The State shall submit this plan to CMS no later than January 1, 2016. CMS will not provide funds to develop or implement such plan. Further, the State will not fund the development of such plan through an increase in hospital rates reimbursed by Maryland Payers and Medicare.

# Graduate Medical Education

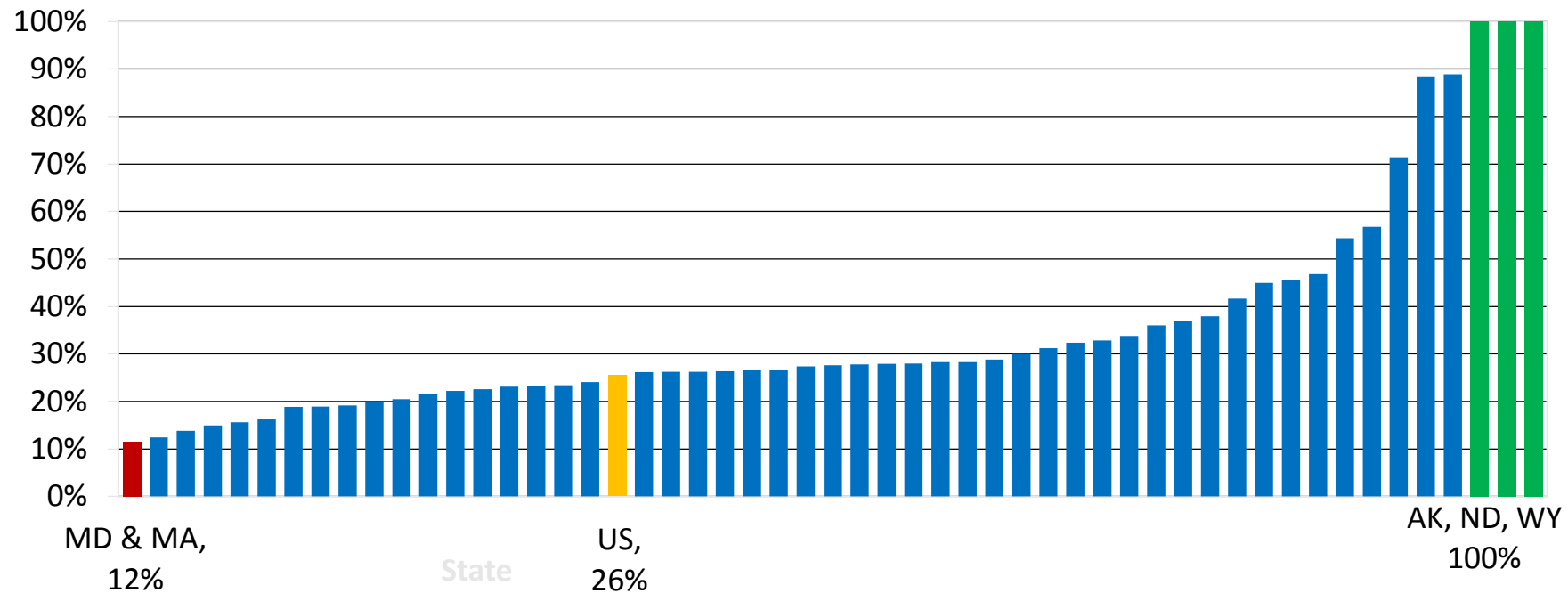
## Areas of Consideration

- Site of Training – Inpatient vs. Non-Inpatient
- Training beyond diagnosis and treatment
  - Care coordination
  - Team Based Care
- Technology Tools
- Workforce Needs



# Graduate Medical Education Workforce Needs

Percentage of residents entering into general practice  
(2011)



Source: *GME in the United States: A Review of State Initiatives Program on Health Workforce Research and Policy at the Cecil G. Sheps Center for Health Services Research*  
[http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/GMEstateReview\\_Sept2013.pdf](http://www.shepscenter.unc.edu/wp-content/uploads/2013/09/GMEstateReview_Sept2013.pdf)

# Reporting on Breakout Session 1

# Introduction to Breakout

## Session 2

### Planning for a New GME Model

# Planning for a New GME Model

- **OBJECTIVE:** Begin to describe in greater detail the steps needed to plan for the new GME Model. Each breakout session will focus on **ONE** of the goals identified in the first breakout session. Participants are to go to the Breakout Session of their choice.
  1. It should be focused on the Triple Aim.
  2. It should include specific curricula that address population health.
  3. It should be funded in an equitable and efficient manner.
  4. It should augment what is good about residency training today.
  5. Other?
- **REPORT OUT:** Initial description of strategies and tactics to achieve the objective.

# Planning for a New GME Model

- **Sample Discussion Questions**

1. In order to achieve this goal, what would have to change in current GME System?
2. Are there common barriers across GME programs in Maryland to achieving this goal?
3. What would be the first thing that needed to happen to begin achieving this goal?
4. Are there unique issues in achieving this goal for particular GME programs by specialty?

# Reporting on Breakout Session 2

# Comments from Secretary Mitchell

**The Honorable Van T. Mitchell**

Secretary, Maryland Department of Health and Mental Hygiene

---



# Closing Comments

**Anthony F. Lehman, MD, MSPH**

Senior Associate Dean for Clinical Affairs, University of Maryland

**Roy C. Ziegelstein, MD, MACP**

Vice Dean for Education, Johns Hopkins School of Medicine



# Next Steps

## June 2015 Workgroup

- Revisit key issues and decision points
- Follow-up discussion on themes from Summit
- Identify additional research / validation needed
- Initial thoughts on Workgroup's recommendations

## September 2015 Workgroup

- Review first draft of report and suggest improvements
- Public testimony

## October 2015 Workgroup

- Review second draft of report and suggest improvements

## November 28

- Delivery Workgroup report

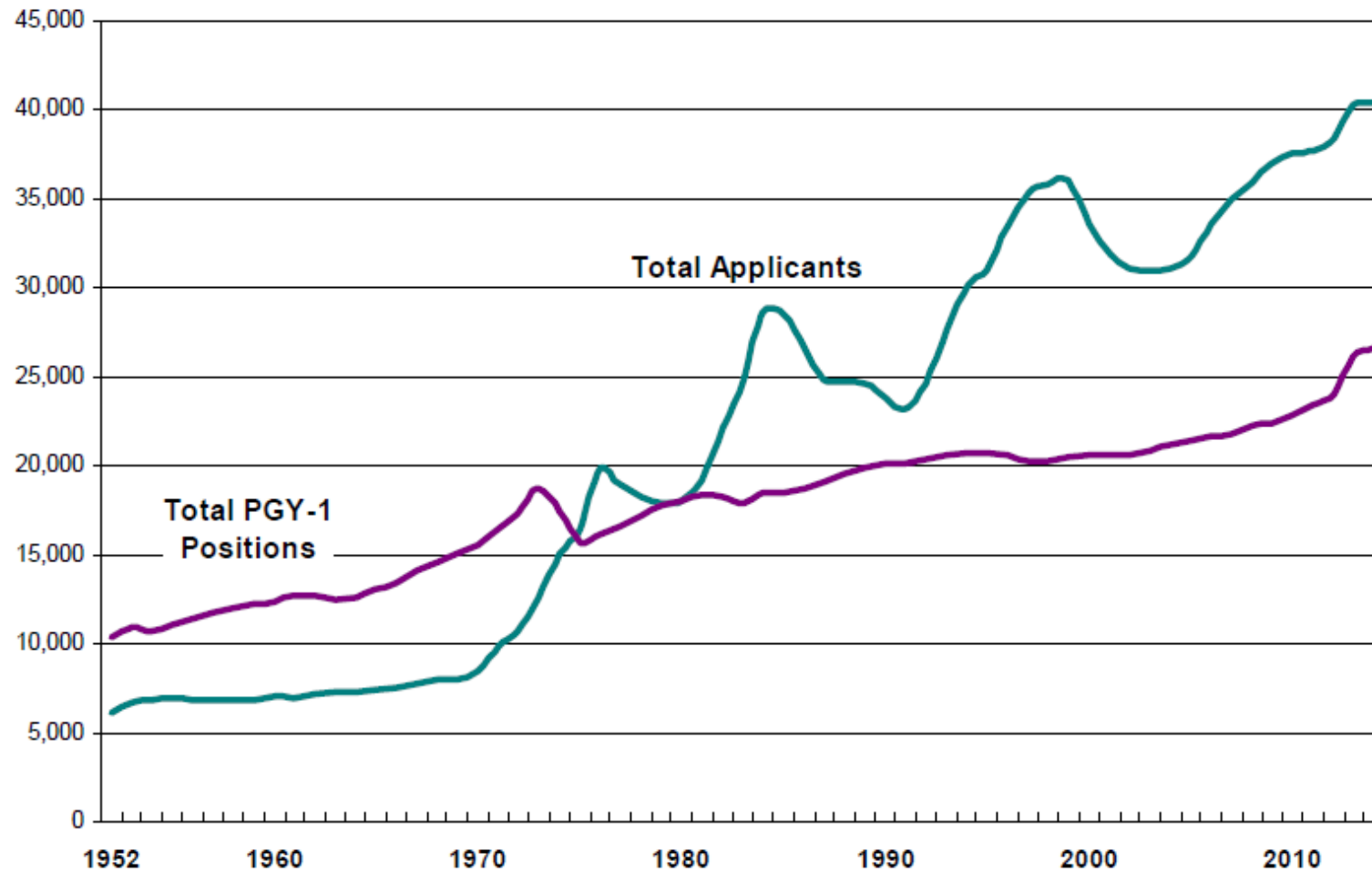
# Appendix

Additional materials from Bruce D. Blumberg, MD

# The Mis-Match

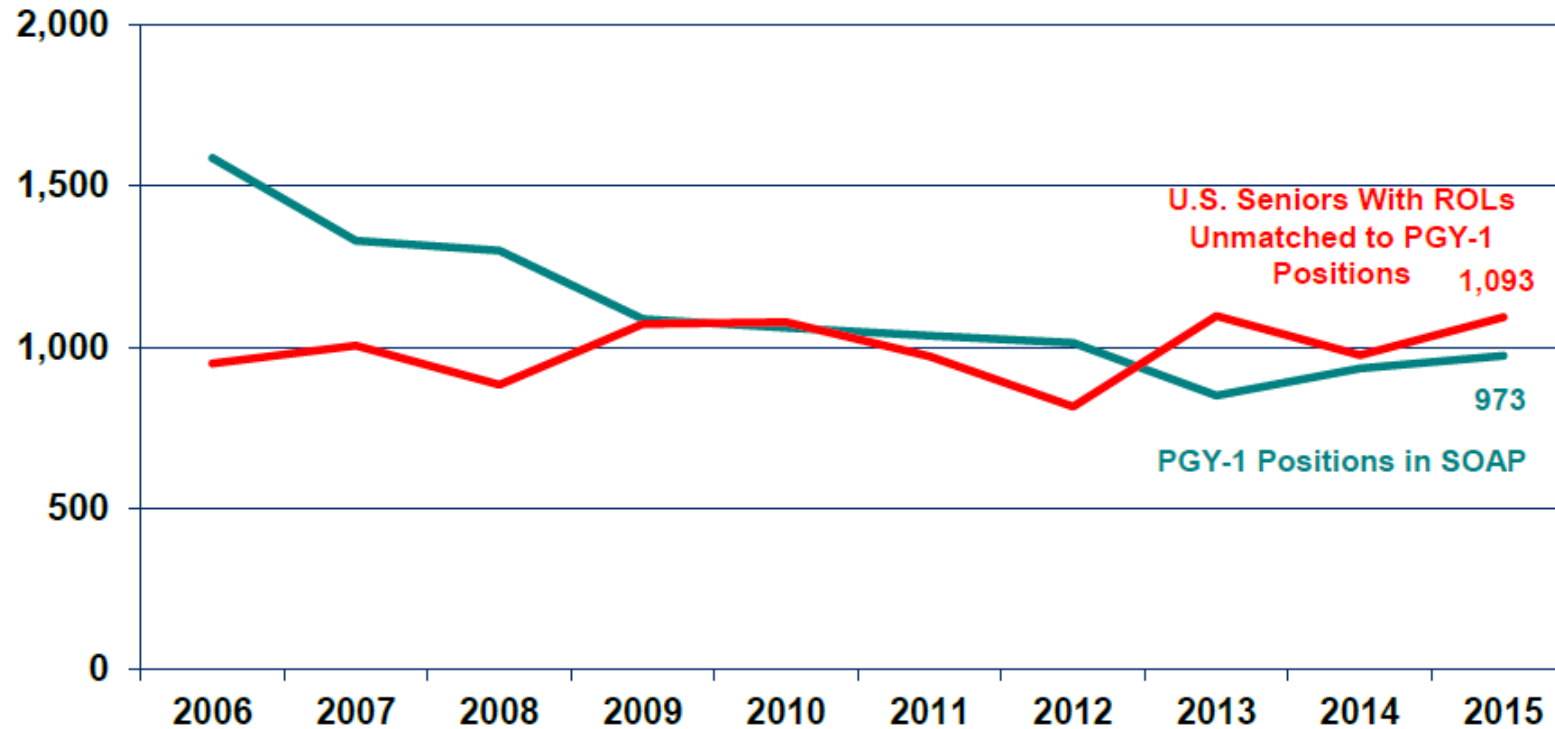
- UME : GME
- Specialty Choice
- Geographic
- Demographic

## Applicants and 1st Year Positions in The Match, 1952 - 2014



# Unmatched Seniors, PGY-1 Positions in SOAP

*More Unmatched Seniors than PGY-1 Positions*



# The Mis-Match

- 2.5% Annual growth rate of U.S. UME matriculants
- 0.9% Annual growth rate of available GME positions

# Growth in NRMP Offered Positions Between 2007 and 2012

Family Medicine	5.3%
Internal Medicine	10.0%
Pediatrics	6.3%
All other (categorical only)	19.7%

# 2015 AAMC Physician Workforce Projections - 2025

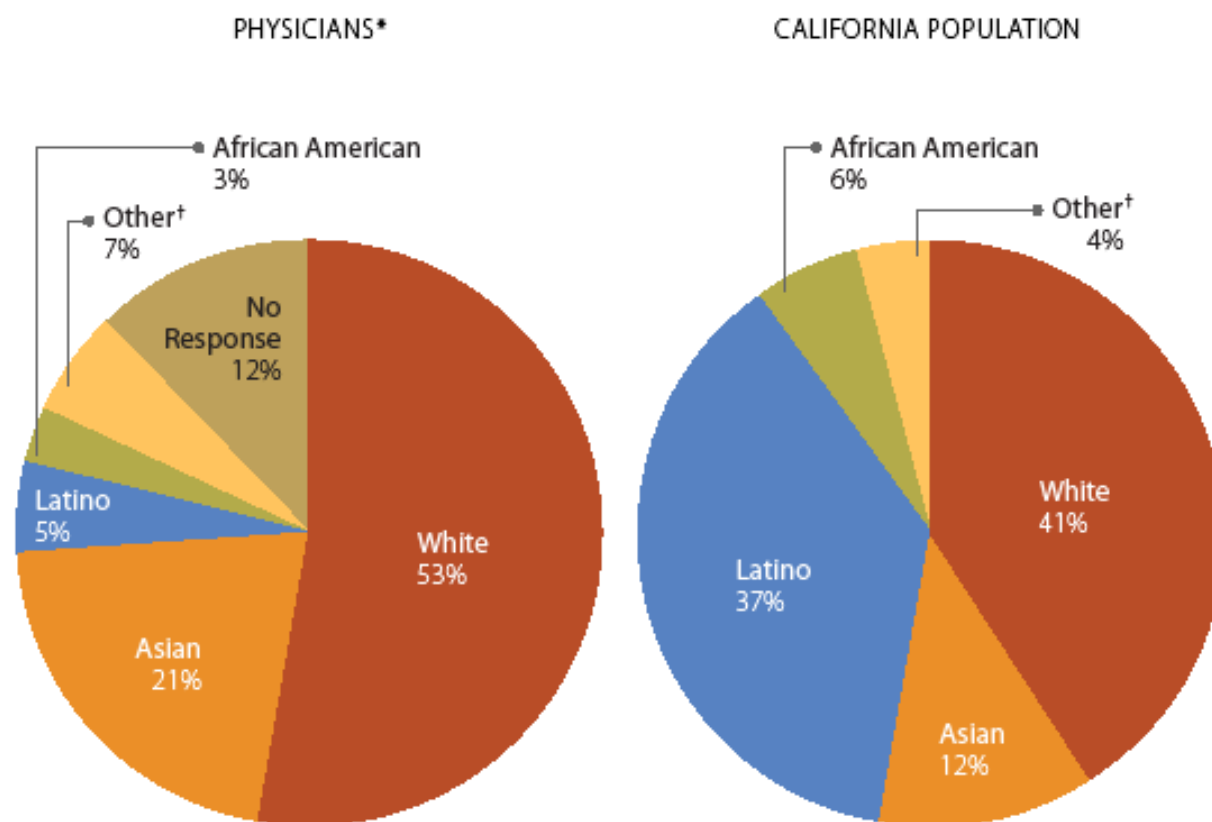
- 46,000 – 90,000 shortfall in physicians
- 12,500 – 31,100 shortfall in primary care
- 5,100 – 12,300 shortfall in medical specialties
- 23,100 – 31,600 shortfall in surgical specialties
- 2,400 – 20,200 shortfall in other specialties



# Identified Gaps in the Physician Workforce

- Number of Physicians
- Physician Demographics
- Specialty mix
- Geographic distribution
- Skill set

## Race/Ethnicity of Physicians and Population, California, 2008



\*Includes only MDs.

†Other includes American Indian, Native American, Alaskan Native, Native Hawaiian, and other.

Note: Segments may not add to 100 percent due to rounding.

Sources: Medical Board of California, 2008 Cultural Background Survey Statistics, [www.mbc.ca.gov](http://www.mbc.ca.gov). U.S. Census Bureau, American Community Survey, population estimates, series GCT-T1-R, [factfinder.census.gov](http://factfinder.census.gov).

The racial/ethnic composition of California's physician workforce does not reflect the state's diversity. While Latinos represent almost 40 percent of the population, only 5 percent of the state's physicians are Latinos.